NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Neonatal parenteral nutrition

NICE quality standard

Draft for consultation

08 November 2021 (consultation)

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| **This quality standard covers** parenteral nutrition (intravenous feeding) for babies born preterm, up to 28 days after their due birth date and babies born at term, up to 28 days after their birth. It describes high-quality care in priority areas for improvement.  This is the draft quality standard for consultation (from 8 November to 6 December 2021). The final quality standard is expected to publish in March 2022. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Preterm and term babies who need neonatal parenteral nutrition receive it as soon as possible, and within 8 hours of the decision to start.

[Statement 2](#_Quality_statement_2:) Preterm and term babies who need neonatal parenteral nutrition are started on a standardised bag.

[Statement 3](#_Quality_statement_X) Preterm and term babies who need neonatal parenteral nutrition receive it through nutrition bags, infusion sets and syringes that are protected from light.

[Statement 4](#_Quality_statement_[X]) Parents and carers of preterm and term babies receiving neonatal parenteral nutrition have regular opportunities to discuss their baby’s care with healthcare professionals.

[Statement 5](#_Quality_statement_[X]) Preterm and term babies receiving neonatal parenteral nutrition are cared for by healthcare professionals with access to a neonatal parenteral nutrition multidisciplinary team.

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. |

# Quality statement 1: Starting parenteral nutrition

## Quality statement

Preterm and term babies who need neonatal parenteral nutrition receive it as soon as possible, and within 8 hours of the decision to start.

## Rationale

## It is important that healthcare professionals consider carefully whether preterm and term babies meet the criteria for parenteral nutrition to avoid delays in providing nutrition. Once the decision is made and documented that parenteral nutrition is needed, it should be started as soon as possible to reduce the risk of nutritional deficit developing, particularly in preterm babies. The timeframe of 8 hours allows for placement of a central line, if needed; however, this should not delay starting parenteral nutrition.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence of local pathways and written clinical protocols to ensure that neonatal parenteral nutrition is considered for preterm and term babies who may not be able to tolerate enteral nutrition.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example, written clinical protocols on neonatal parenteral nutrition and staff training records.

b) Evidence of local arrangements to ensure that standardised bags are available to use on neonatal units.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example, stock records of standardised bags.

### Process

Proportion of preterm and term babies who receive neonatal parenteral nutrition within 8 hours of the decision to start it.

Numerator – the number in the denominator who receive neonatal parenteral nutrition within 8 hours of the decision to start it.

Denominator – the number of preterm and term babies who receive neonatal parenteral nutrition.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

### Outcome

Time from decision to give neonatal parental nutrition to it being administered.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

## What the quality statement means for different audiences

**Service providers** (such as neonatal units and pharmacy services) ensure that systems are in place for babies to receive neonatal parenteral nutrition within 8 hours of the need being identified. This includes having standardised bags available and access to a healthcare professional who can place a central line if needed.

**Healthcare professionals** (such as neonatal consultants, neonatal pharmacists and neonatal dietitians) are aware of the indications that a baby may need parenteral nutrition and consider whether this is needed at birth or when enteral or oral feeding is reduced or stopped. They ensure that when the decision is made and documented to give neonatal parenteral nutrition, it is started within 8 hours. This allows time for a central line to be placed, if needed.

**Commissioners** (such as clinical commissioning groups, integrated care systems and NHS England) ensure that they commission services that have systems in place to administer neonatal parenteral nutrition to preterm and term babies within 8 hours of the decision to give parenteral nutrition.

**Newborn babies who need to be given nutrition directly into their bloodstream through a vein (intravenously)** start this within 8 hours of the healthcare professionals caring for them identifying that it is needed. The nutrition provides babies who are unable to have milk feeds with vital energy and nutrients to help them grow.

## Source guidance

[Neonatal parenteral nutrition. NICE guideline NG154](https://www.nice.org.uk/guidance/NG154) (2020), recommendation 1.1.6

## Definitions of terms used in this quality statement

### Neonatal parenteral nutrition

Nutrition given directly into the bloodstream through a vein (intravenously) in newborn babies who cannot take milk feeds because they are too small or very unwell. The neonatal period is defined as up to 28 days after birth for babies born at term and 28 days after their due birth date for those born preterm. [Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), overview and information for the public]

### Criteria for starting neonatal parenteral nutrition

Healthcare professionals should consider neonatal parenteral nutrition for:

* preterm babies born before 31 weeks of pregnancy
* preterm babies born at or after 31 weeks of pregnancy if sufficient progress is not made with enteral feeding in the first 72 hours after birth
* preterm and term babies who are unlikely to establish sufficient enteral feeding, for example, babies with:
  + a congenital gut disorder
  + a critical illness such as sepsis
* preterm babies on enteral feeds if:
  + enteral feeds have to be stopped and it is unlikely they will be restarted within 48 hours
  + enteral feeds have been stopped for more than 24 hours and there is unlikely to be sufficient progress with enteral feeding within a further 48 hours
* term babies on enteral feeds if:
  + enteral feeds have to be stopped and it is unlikely they will be restarted within 72 hours
  + enteral feeds have been stopped for more than 48 hours and there is unlikely to be sufficient progress with enteral feeding within a further 48 hours.

[Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/ng154), recommendations 1.1.1, 1.1.2, 1.1.3, 1.1.4 and 1.1.5]

# Quality statement 2: Standardised bags

## Quality statement

Preterm and term babies who need neonatal parenteral nutrition are started on a standardised bag.

## Rationale

Using standardised neonatal parental nutrition formulation (standardised bags) improves consistency in nutritional care, reduces variation in practice and reduces the risk of errors that can occur when making up non-standardised bags. They also enable the early delivery of neonatal parenteral nutrition because they can always be available on neonatal units and easily accessed when needed.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence of local arrangements and written clinical protocols to ensure that preterm and term babies who need neonatal parenteral nutrition are started on standardised bags.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example, copies of written protocols and evidence of availability of standardised bags on units.

b) Evidence of local arrangements to ensure that standardised bags are available to use on neonatal units.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example, stock records of standardised bags.

### Process

Proportion of preterm and term babies who receive neonatal parenteral nutrition who are started on a standardised bag.

Numerator – the number in the denominator who are started on a standardised bag.

Denominator – the number of preterm and term babies who receive neonatal parenteral nutrition.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

### Outcome

Number of neonatal parenteral nutrition prescribing errors.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records and incident reporting.

## What the quality statement means for different audiences

**Service providers** (such as neonatal units and pharmacy services) ensure that standardised bags, containing the suitable levels of nutritional content, are easily available for use on neonatal units to ensure neonatal parenteral nutrition can be safely and promptly administered. They ensure that staff are trained to use standardised bags for preterm and term babies who need neonatal parenteral nutrition.

**Healthcare professionals** (such as neonatal consultants and neonatal pharmacists) start neonatal parenteral nutrition using a standardised bag.

**Commissioners** (such as clinical commissioning groups, integrated care systems and NHS England) ensure that they commission services in which standardised bags of neonatal parenteral nutrition are available for use on neonatal units and used when parenteral nutrition is started.

**Newborn babies who need to be given nutrition directly into their bloodstream through a vein (intravenously)** are given a type of nutrition that is suitable for most babies called a ‘standardised bag’. Standardised bags can be kept on the neonatal unit, so they are ready to use quickly, which avoids delays in giving babies the nutrition they need.

## Source guidance

[Neonatal parenteral nutrition. NICE guideline NG154](https://www.nice.org.uk/guidance/NG154) (2020), recommendation 1.6.1

## Definitions of terms used in this quality statement

### Neonatal parenteral nutrition

Nutrition given directly into the bloodstream through a vein (intravenously) in newborn babies who cannot take milk feeds because they are too small or very unwell. The neonatal period is defined as up to 28 days after birth for babies born at term and 28 days after their due birth date for those born preterm. [Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), overview and information for the public]

### Standardised bags

Standardised bags contain pre-formulated aqueous and lipid parenteral nutrition solutions made to a set composition. They are ready to use and aim to meet the nutritional and clinical needs of a defined group of babies. Additional intravenous infusions are sometimes used to meet more individualised fluid or electrolyte requirements.

A choice of standardised bags is available to ensure that the nutritional and clinical needs of a defined group of babies can be met.

[Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), terms used in this guideline]

# Quality statement 3: Light protection

## Quality statement

Preterm and term babies who need neonatal parenteral nutrition receive it through nutrition bags, infusion sets and syringes that are protected from light.

## Rationale

Parenteral nutrition solutions need to be protected from light to help prevent potentially harmful photo-degradation and oxidation. This ensures that the solution maintains its nutritional levels and is safe to use. It is important to protect the syringes and infusion sets during use as well as protecting the bags of parenteral nutrition solution at all times.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence of local arrangements and written clinical protocols that ensure that bags, syringes and infusion sets of parenteral nutrition solutions are protected from light.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, copies of written protocols and evidence of staff training.

b) Evidence of local arrangements that ensure that light protection is available for bags, syringes and infusion sets of parenteral nutrition solutions.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, procurement and stock records.

### Process

Proportion of neonatal parenteral nutrition bags, infusion sets and syringes that were protected from light while being administered to preterm and term babies.

Numerator – the number in the denominator that were protected from light.

Denominator – the number of neonatal parenteral nutrition bags, infusion sets and syringes that were administered to preterm and term babies.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

### Outcome

Number of light exposure incidents during delivery of neonatal parenteral nutrition.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from incident reporting and patient records.

## What the quality statement means for different audiences

**Service providers** (such as neonatal units and pharmacy services) ensure that light protection for bags, syringes and infusion sets of parenteral nutrition solutions is available, and that staff are trained to use it. They ensure that neonatal parenteral nutrition bags are protected from light when they are stored and that the bags, syringes and infusion sets are protected when neonatal parenteral nutrition is being given.

**Healthcare professionals** (such as neonatal consultants, neonatal nurses and neonatal pharmacists) are trained to use light protection for bags, syringes and infusion sets of parenteral nutrition solutions. They ensure that the neonatal parenteral nutrition bags are protected from light at all times and the syringes and infusion sets are protected when neonatal parenteral nutrition is being given.

**Commissioners** (such as clinical commissioning groups, integrated care systems and NHS England) ensure that they commission services that have systems in place to administer neonatal parenteral nutrition safely.

**Newborn babies who need to be given nutrition directly into their bloodstream through a vein (intravenously)** are given nutrition that is protected from light. Protecting the bags of nutrition and the tubes and syringes used to give it from light helps to ensure that the nutritional levels are maintained, and it is safe to use.

## Source guidance

[Neonatal parenteral nutrition. NICE guideline NG154](https://www.nice.org.uk/guidance/NG154) (2020), recommendation 1.2.3

## Definitions of terms used in this quality statement

### Neonatal parenteral nutrition

Nutrition given directly into the bloodstream through a vein (intravenously) in newborn babies who cannot take milk feeds because they are too small or very unwell. The neonatal period is defined as up to 28 days after birth for babies born at term and 28 days after their due birth date for those born preterm. [Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), overview and information for the public]

# Quality statement 4: Involving parents and carers

## Quality statement

Parents and carers of preterm and term babies receiving neonatal parenteral nutrition have regular opportunities to discuss their baby’s care with healthcare professionals.

## Rationale

It is challenging and stressful for parents and carers to have a baby being cared for in a neonatal unit. Therefore, it is important that parents and carers are given regular opportunities to discuss their baby’s care with their healthcare professionals. This will help to ensure that they understand the care their baby is receiving and help them to feel supported and involved.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local arrangements to ensure that parents and carers of preterm and term babies receiving neonatal parenteral nutrition have regular opportunities to discuss their baby’s care with their healthcare professionals.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally, for example, written protocols for communication with parents on the neonatal unit and involving them in ward rounds, or specific time allocated in healthcare professionals’ schedules for speaking with parents and carers.

### Outcome

Proportion of parents and carers of preterm and term babies receiving neonatal parenteral nutrition who are satisfied with communication with healthcare professionals.

Numerator – the number in the denominator who are satisfied with communication with healthcare professionals.

Denominator – the number of parents and carers of preterm and term babies receiving neonatal parenteral nutrition.

**Data source:**Data can be collected from information recorded locally, for example, from patient records and from local surveys of parent and carer experience. The [National Neonatal Audit Programme](https://nnap.rcpch.ac.uk/) collects data on parental consultation within 24 hours of admission and parental presence at a consultant ward round.

## What the quality statement means for different audiences

**Service providers** (neonatal units) ensure that systems are in place for parents and carers to have regular opportunities to discuss their baby’s care with the healthcare professionals caring for them. This can include parents and carers joining ward rounds, having time to have meaningful discussions with their baby’s consultant and their neonatal nurses, and knowing when staff members will be available to speak to them. Healthcare professionals’ schedules should have specific times allocated to allow them to arrange opportunities to speak with parents and carers, and they should have training on how to speak with parents and carers who may be distressed. Evidence-based written information can also be given to parents and carers for them to read through and discuss with their healthcare professionals at an agreed time.

**Healthcare professionals** (such as neonatal consultants, neonatal nurses, neonatal dietitians and neonatal pharmacists) have allocated time to speak with parents and carers of preterm and term babies receiving neonatal parenteral nutrition. They understand that having a baby who is receiving neonatal parenteral nutrition can be distressing for parents and are mindful of this when discussing the baby’s care with them. They ask parents and carers how and when they would like to receive information and updates, and how much information they would like about their baby's care. They give clear explanations of the care the baby is receiving and give parents and carers opportunities to ask questions.

**Commissioners** (such as clinical commissioning groups, integrated care systems and NHS England) ensure that they commission services in which parents and carers of preterm and term babies receiving parenteral nutrition have regular opportunities to discuss their baby’s care with healthcare professionals. They ensure that they commission services in which healthcare professionals have specific time allocated to allow them to arrange times to speak with parents and carers.

**Parents and carers of newborn babies who are being given nutrition directly into their bloodstream through a vein (intravenously)** have regular opportunities to talk to the healthcare professionals caring for their baby. They are given written information that they can discuss with their healthcare professional, and they are able to ask any questions and discuss any concerns they have about their baby’s care.

## Source guidance

[Neonatal parenteral nutrition. NICE guideline NG154](https://www.nice.org.uk/guidance/NG154) (2020), recommendation 1.10.4

## Definitions of terms used in this quality statement

### Neonatal parenteral nutrition

Nutrition given directly into the bloodstream through a vein (intravenously) in newborn babies who cannot take milk feeds because they are too small or very unwell. The neonatal period is defined as up to 28 days after birth for babies born at term and 28 days after their due birth date for those born preterm. [Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), overview and information for the public]

## Equality and diversity considerations

Parents and carers should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with the healthcare professionals caring for their baby. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. Parents and carers should have access to an interpreter or advocate if needed.

For parents and carers with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 5: Neonatal parenteral nutrition multidisciplinary team

## Quality statement

Preterm and term babies receiving neonatal parenteral nutrition are cared for by healthcare professionals with access to a neonatal parenteral nutrition multidisciplinary team.

## Rationale

Access to a neonatal parenteral nutrition multidisciplinary team helps to ensure a safe and effective service. The multidisciplinary team can support healthcare professionals, for example, by ensuring there are protocols for starting and stopping neonatal parenteral nutrition and by assisting with complex cases.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

Evidence of local arrangements to ensure that healthcare professionals have access to a neonatal parenteral nutrition multidisciplinary team.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally, for example, evidence that a neonatal parenteral nutrition multidisciplinary team is available and staff know how to access it.

### Process

Proportion of neonatal units with access to a neonatal parenteral nutrition multidisciplinary team.

Numerator –the number in the denominator with access to a neonatal parenteral nutrition multidisciplinary team.

Denominator –the number of neonatal units.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local service agreements.

## What the quality statement means for different audiences

**Service providers** (such as neonatal clinical networks and neonatal units) ensure that healthcare professionals caring for babies receiving neonatal parenteral nutrition have easy access to a neonatal parenteral nutrition multidisciplinary team. This can be a locally based multidisciplinary team or part of the neonatal clinical network.

**Healthcare professionals** (such as neonatal consultants, neonatal nurses, neonatal dietitians and neonatal pharmacists) access the neonatal parenteral nutrition multidisciplinary team if they need clinical advice, assistance or are treating a baby with complex needs.

**Commissioners** (such as clinical commissioning groups, integrated care systems and NHS England) ensure that they commission services that provide neonatal parenteral nutrition multidisciplinary teams and ensure they are available to healthcare professionals in neonatal units when needed. The multidisciplinary teams are responsible for governance and provide support for healthcare professionals delivering neonatal parenteral nutrition.

**Newborn babies who are being given nutrition directly into their bloodstream through a vein (intravenously)** are cared for by healthcare professionals who can easily access other specialists in neonatal nutrition for advice and support.

## Source guidance

[Neonatal parenteral nutrition. NICE guideline NG154](https://www.nice.org.uk/guidance/NG154) (2020), recommendation 1.9.1

## Definitions of terms used in this quality statement

### Neonatal parenteral nutrition

Nutrition given directly into the bloodstream through a vein (intravenously) in newborn babies who cannot take milk feeds because they are too small or very unwell. The neonatal period is defined as up to 28 days after birth for babies born at term and 28 days after their due birth date for those born preterm. [Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), overview and information for the public]

### Neonatal parenteral nutrition multidisciplinary team

The neonatal parenteral nutrition multidisciplinary team should include a consultant neonatologist or paediatrician with a special interest in neonatology, a neonatal pharmacist and a neonatal dietitian, and should have access to the following:

* a neonatal nurse
* a paediatric gastroenterologist
* an expert in clinical biochemistry.

It should be responsible for:

* governance, including:
  + agreeing policies and protocols for the neonatal parenteral nutrition service, including when neonatal parenteral nutrition should be discontinued
  + ensuring that policies and protocols for neonatal parenteral nutrition are followed and audited
  + monitoring clinical outcomes
* supporting delivery of parenteral nutrition, including:
  + providing clinical advice
  + providing enhanced multidisciplinary team input for preterm and term babies with complex needs, for example, babies with short bowel syndrome who may need long-term parenteral nutrition.

The neonatal parenteral nutrition multidisciplinary team can be based locally or within a clinical network. It does not need to discuss or review all preterm and term babies receiving neonatal parenteral nutrition.

[Adapted from [NICE’s guideline on neonatal parenteral nutrition](https://www.nice.org.uk/guidance/NG154), recommendations 1.9.1, 1.9.2 and 1.9.3, and expert opinion.]

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standard advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10087).

This quality standard has been included in the [NICE Pathway on neonatal parenteral nutrition](https://pathways.nice.org.uk/pathways/neonatal-parenteral-nutrition), which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact statement](https://www.nice.org.uk/guidance/ng154/resources) for the NICE guideline on neonatal parenteral nutrition to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10087/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN:

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